AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
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25 November 2019

Nicholas Jones

By email: Nicholas.Jones@nzme.co.nz

Dear Nicholas

Re: Official Information Act request – Communication between Te Whetu Tawera re patient safety

I refer to your Official Information Act request dated 25 October 2019 requesting the following information.

With respect, I request the following information under the terms of the Official Information Act 1982:

1. **Copies any reports, documents, memoranda, correspondence, legal advice or emails, both internal and external regarding:**
2. **Since July 1 2019, communication to and from the four adult service groups that refer service users for admission to the Auckland DHB Mental Health Adult Acute Inpatient Service Te Whetū Tāwera, regarding frustration or concern over admissions being delayed or not accepted, including any concern over patient safety.**

Any memo, document or briefing that outlines the reasons for the Patient Flow Project, which is outlined on page 73 of the below minutes:

https://www.adhb.health.nz/assets/Uploads/Open-HAC-meeting-pack-16-October-2020.pdf

This request is designed to capture communications that relate to rising tensions between the service groups and the inpatient service, mentioned in the above minutes:

"The on-going challenges associated with increased demand, along with challenges associated with the way in which the role is currently operating, have contributed to an

increasing level of tension between inpatient and community services across the four adult service groups."

As context and as outlined in the Northern Region Long Term Investment Plan, Auckland DHB has a rapidly growing and aging population which is resulting in increased demand for all our services.

In terms of: "The on-going challenges associated with increased demand, along with challenges associated with the way in which the role is currently operating, have contributed to an increasing level of tension between inpatient and community services across the four adult service groups", which was mentioned in the HAC agenda, it is helpful context to understand that this refers to natural tensions that have arisen between professionals in the community and in the hospital setting, all committed to providing the best possible service to their patients. We acknowledged that the system was not working as well as it could be and took action to address this, implementing the Patient Flow project.

The Patient Flow project started in March 2019, with the aim of understanding the problems of flow through Te Whetu Tawera (adult acute mental health inpatient unit) which was constantly at capacity.

Since the implementation of this project inpatient and community services have taken a joined up approach to resolving the complex issues underlying the inpatient unit regularly being at capacity.

The following documents are appended as they relate to this project:

- Appendix A: Mental Health and Addiction Services Patient Flow Project Close Report, dated 17/9/19 (Appendix C- DAS, has been removed as this contains patient names)
- Appendix B: PowerPoint presentation of the MH Acute Flow Project
- Appendix C: draft of proposed changes to the Acute Admission Coordinator role, dated 13/5/19

The balance of your request is problematic, as "communication to and from the four adult service groups that refer service users for admission to the Auckland DHB Mental Health Adult Acute Inpatient Service Te Whetū Tāwera" will not be generic. These communications are patient specific and will invariably integrate clinical comments about a patient and their situation. This information must be withheld to protect the privacy of these patients.

So, while we have been able to locate a small number of communications that include "frustration or concern over admissions being delayed or not accepted, including any concern over patient safety", what is set out below is essentially only the concern expressed:

1. Internal email relating to a patient admission:

   From: John Jacques (ADHB)
   Sent: Thursday, 04 July 2019 4:18 p.m.
   To: Pauline McKay (ADHB)
   Subject: RE: X

   Six admissions! Crikey.
   Thanks for your help with this

I am not sure if we have anyone on BRC waitlist at TWT- I will check with Michael Breen first thing tomorrow and get back to you.

Best wishes

John.

From: Pauline McKay (ADHB)
Sent: Thursday, 04 July 2019 3:51 p.m.
To: John Jacques (ADHB); Mark Sutherland (ADHB); Allen Fraser (ADHB); Louise Martin (ADHB); Anne Frew (ADHB)
Subject: Re: X

Thanks John Jacques

Currently the ICU is brimming... 6 admission today.
May need to consider remaining in the at risk unit until better picture of beds.
Will be liaising with the SCDs regarding TWT being at capacity tonight and need for community teams to identify earlier than likes discharges ASAP tomorrow.

2. Datix Sept 19:

Attempts by community team to readmit were unsuccessful, as we were advised that due to bed shortage she would not be prioritised as she was not of an imminent risk.

Datix Oct 19:

The ward rang Taylor Centre to inform us that she had been discharged due to pressure on beds and to follow up when XX was under the impression that she as a voluntary patient could approach her GP to continue her treatment.

3. The following are copied from the Duty Manager notes at Te Whetu Tawera, with names anonymised:

   a. July 19: *1610hrs XX from URS called to request an ICU bed for this lady. I explained that we don't currently have an ICU bed, so the OC Consultant would need to review someone for transfer – and that there may not be anyone suitable for transfer. 1810hrs XX called to say that the MHA has been completed and they require an ICU bed. I advised that we still don't have one and that the OC Consultant will need to attend the unit to review people to make one. 1935hrs a person was CFT, so I informed URS that we could facilitate an admission from 2030hrs onwards. 2010hrs Chen called to say that they were on the way, but will wait in the assessment suite until ICU can admit.*

   b. August 19: *OCReg informed me that YY is currently in AED for medical Ax as collapsed yesterday. He has been agitated in AED. I informed her about bedstate and there is no ICU bed currently. Still await for medical clearance so referred back to medical team.*

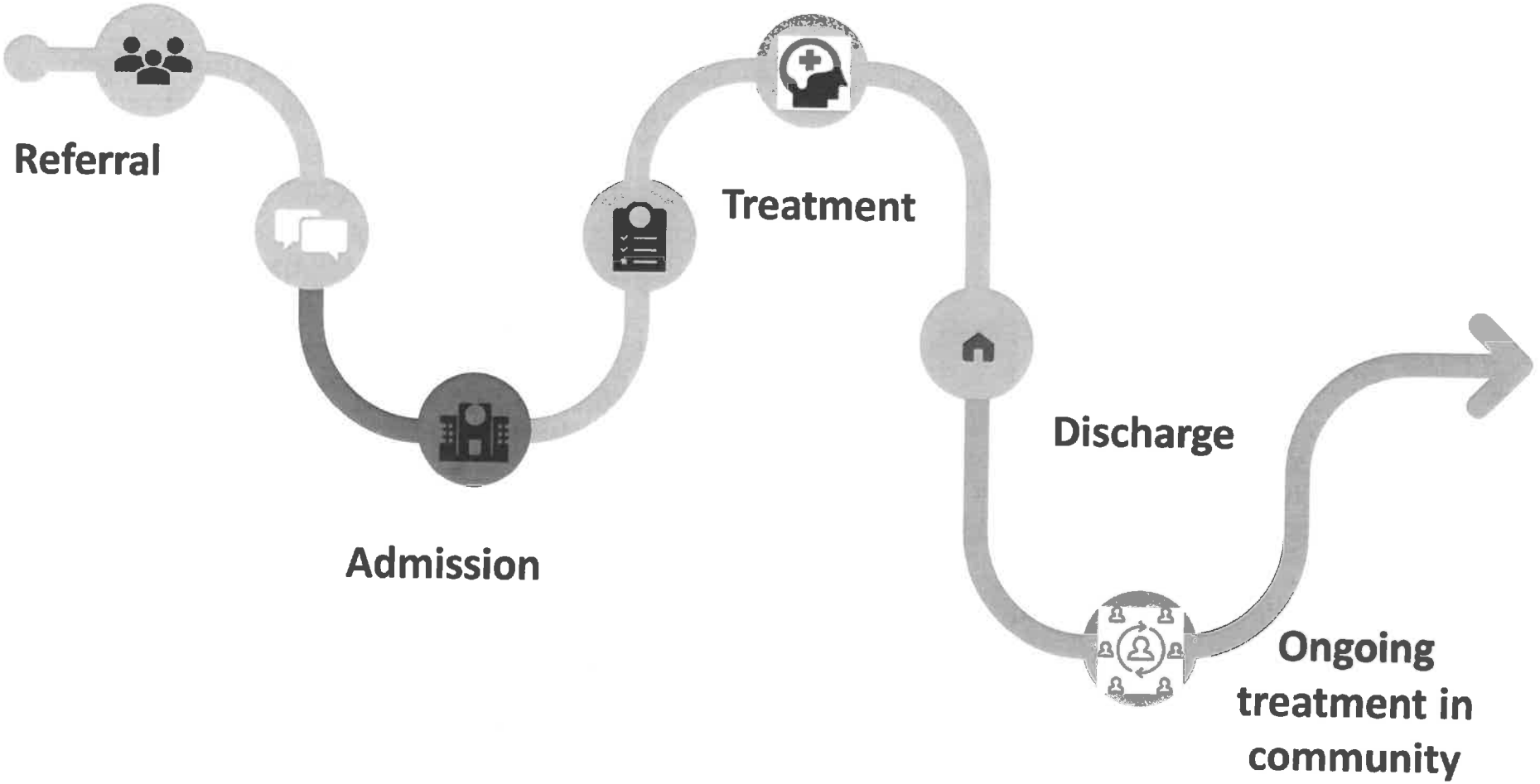
You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive

MH Acute Flow Project



Problem statement

Present State
(where we are now)

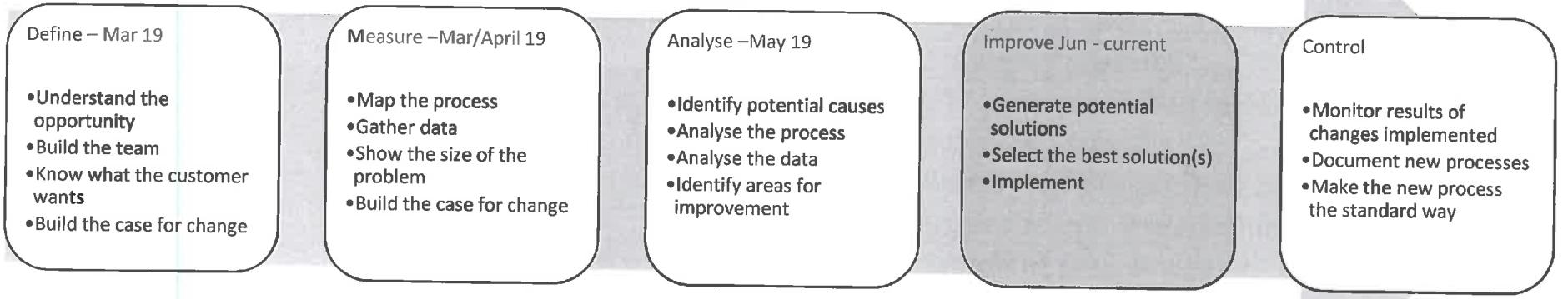
1. ADHB Mental Health Adult Acute Inpatient Service **Te Whetu Tawera (TWT) is constantly at capacity.** The CMHCs that refer the majority of service users for admission have an **Increased demand** for services and **increased acuity** and level of unwellness which has contributed to further demand on beds at TWT.
2. The majority of **admissions (70%) occur outside of standard hours** of 8am to 4pm
3. Number of **additional occupied bed days** for patients with **barriers to discharge totalled 2221** days over a 10 month period (May 2018 to Mar 19)
4. With **limited visibility of the capacity of the entire service** (TWT, community, respite, NGO beds) there can be further delays to admission.

Target Condition
(where we want to be)

1. Occupancy reduced to national KPI 85%
2. Develop/ refine enablers for integrated care delivery (shared care plans, admission goals, discharge planning) to facilitate flow
3. Increased admissions earlier in the day
4. Improved experience for service users and whanau

Project Process/ Methodology

- Used a process improvement approach (DMAIC) facilitated by an Improvement Project manager from the Performance Improvement Team
- Currently in Improve phase



Outputs

- Problem statement – why change?
- Scope
- Goal / Vision
- Voice of Patient
- Voice of Staff
- Stakeholders Analysis
- Comms Plan Initiated

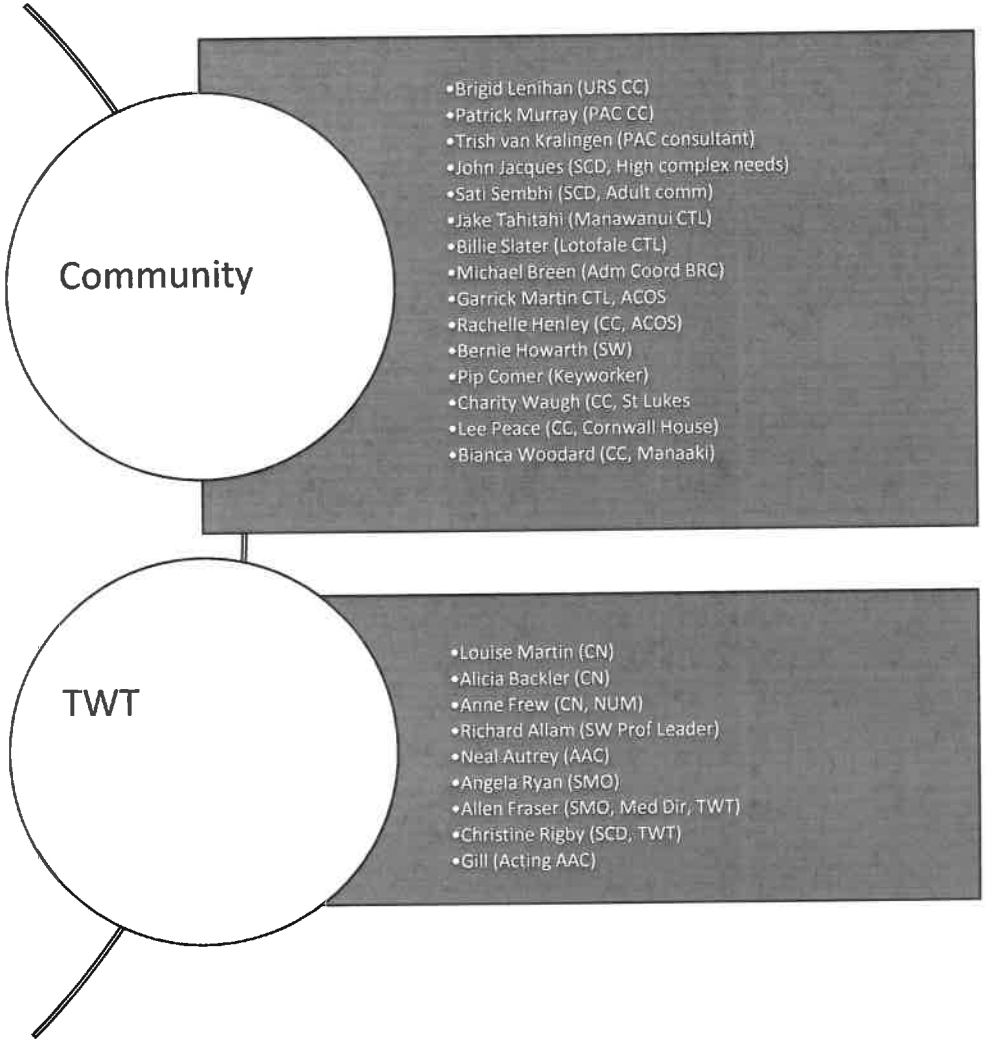
- Establish key measures
- Baseline performance
- High Level Process

- Causes – why
- Data Analysis
- Benchmarking Prioritise areas to focus improvements

- Design improvements
- HEAT tool evaluation for equity impact
- Test and Implement Improvements
- PDSA
- Analyse performance of pilot – incl patient feedback
- Plan formal implementation

- Confirm process owner
- Visual performance monitoring
- Benefits realisation

The project team and the workshops



- Weekly workshops were held
- Multidisciplinary approach with representation from Community and Inpatient TWT teams
- After the first 3 workshops with a larger group, we broke into 3 smaller working groups to address
  - Admission and referral
  - Care Planning
  - Discharge

MH Patient Flow root causes

Process for triage and admission not optimal

Mon to Fri operation for some services, resources and roles

Care planning and integration bet CMHS and TWT not consistent

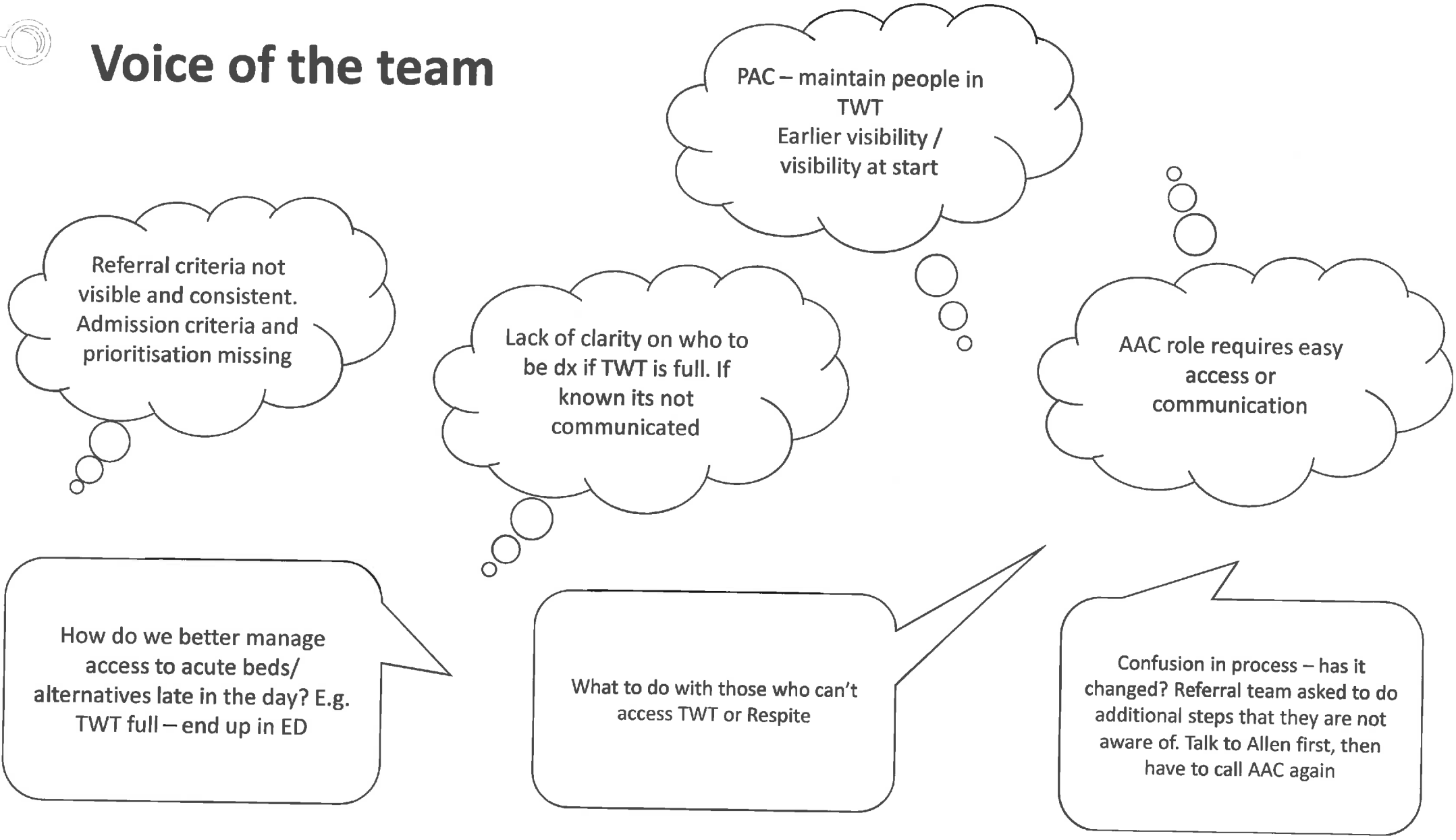
Discharge planning starting time inconsistent

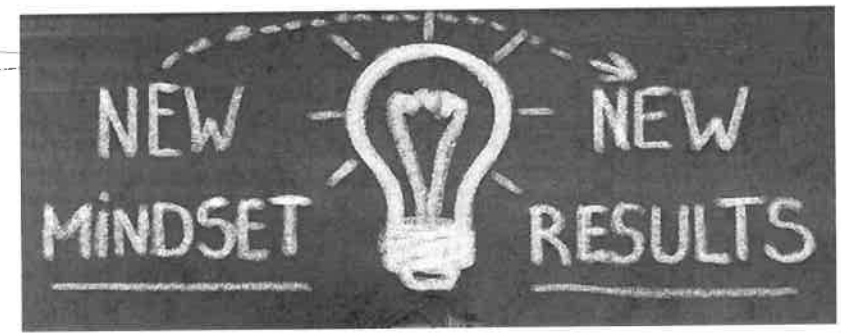
Insufficient collaboration between community and TWT for unplanned discharges

Barriers to discharge impact LOS

Voice of the team

Voice of the team





Working to develop the ideal patient pathway required the team to create a new mind set … and the team came up with this to help focus future efforts

Being open to new ideas

Cultural responsiveness

Equity and sharing of resources

Understand everyone's roles

Working together as ONE service/ a single team around the client and family

Putting cynicism aside

Whanau/ family collaboration

Stakeholder collaboration

Communication is timely and effective

Transparency

Flexibility

Earlier intervention

Respect and consideration

Measures to track success

- Admissions by time of day
- Occupancy at Friday midday ≤ 85%
- LOS

Group work

- In each group
  - Define the high level process
  - Decide what we want to do at each stage?
    - Could be new processes or continue with existing
    - How will we deal with exceptions?
    - Think about the 80/20 rule – the process should fit 80% of the situations
  - Define what tools are required for each part of the process

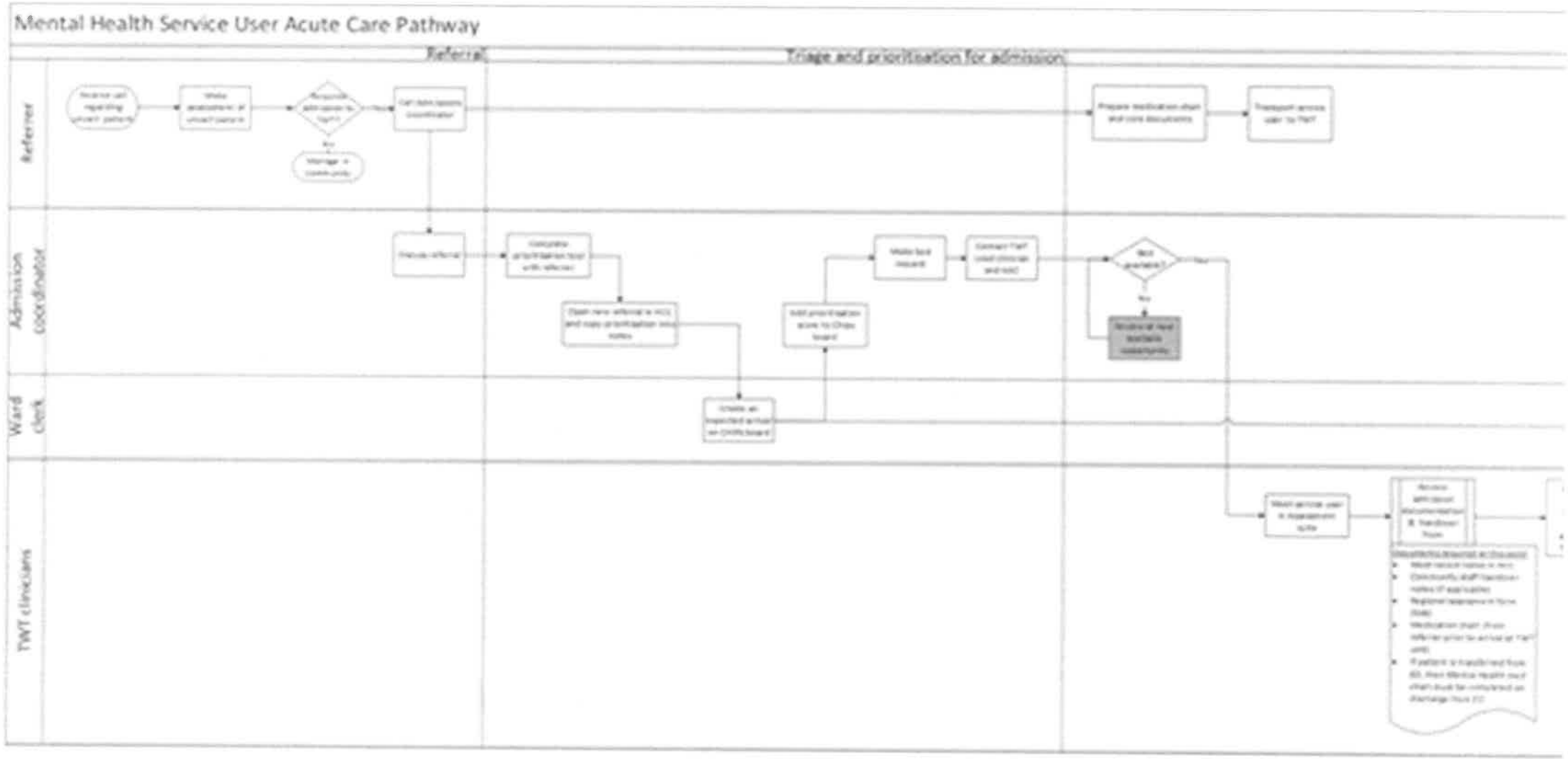
Solutions identified for Implementation

- Updated acute care pathway (referral, care, discharge)
- Prioritisation tool
- Use of Chips whiteboard
- Enabling Zoom technology across all services to make meetings more effective
- Use of the Transition lounge on Level 5 for patients who are ready to go home
- Updated meetings as part of inpatient stay
  - New format MDM
  - New Care planning meeting (to replace TPM, DPM) with earlier discharge planning
  - Immediate discharge process (for urgent discharges)

Next steps

- Project handover to Implementation phase led by SCDs and Ops Managers
- Communication to staff about project

Appendix 1 – New Care pathway



Appendix 2 - Prioritisation tool

Prioritisation Criteria	Answer	Score		
MH Act	Yes	1		
All community options have been considered (respite/ PAC/ family)	Yes	1		
Current location (Police = 3, ED = 2, Community (home/CMHC/respite = 1)	Police (or police on the way)	3		
Not responding to assertive treatment OR refusing meds	Yes	1		
Significant consequences of not being admitted?	Yes	1		
Imminent risk or unpredictable risk	Yes	1		
Previous or recent non-response to community management	Yes	1		
Code called	Yes	1		
Cumulating vulnerability likely to lead to risk	Yes	1		
Level of risk (High = 3, Medium =2, Low = 1)	3	3	double dipping ??	
Total score for prioritisation		14		
			Historic - predisposing elements	
Predisposing elements				
Presenting symptoms				
Protective ?(Family environment)				
Perpetuating				
Precipitating				

Mental Health and Addiction Services Patient Flow

Project Close Report

Document authorisation & control

	Version	Release date	Author	Authoriser
Version history	0.1	23/08/2019	Malini Subramoney	
	1.0	17/09/2019	Malini Subramoney	

Associated documents	Mental Health Acute Care Pathway				
Purpose	This report formally closes the Mental Health and Addiction Services Patient Flow project. This approval represents acceptance of the final project deliverable, and, based on the information in this report, releases all Performance Improvement resources from this project. The performance information will be recorded and relevant information, such as the lessons learned and any improvements will be shared with other projects, as part of Auckland DHB's commitment to continuous improvement.				
Project Sponsor	Anna Schofield	*Signature*		*Date*	
Project Manger	Malini Subramoney	*Signature*		*Date*	17/09/2019

1. Background

1.1 Executive summary	ADHB Mental Health Adult Acute Inpatient Service Te Whetu Tawera (TWT) is constantly at capacity. The CMHCs that refer the majority of service users for admission have an increased demand for services and increased acuity which has contributed to further demand on beds at TWT. With limited visibility of the capacity of the entire service (TWT, community, respite, NGO beds) there can be further delays to admission. Currently, the majority of admissions occur after 4pm. There does not appear to be a systematic way in which timely discharge planning occurs. The pressure for in-patients beds can often mean service users are discharged before they are clinically ready. The impact is negative service user experience and outcome, increased pressure on the community mental health service groups, and increased risk to service users due to the inability to access to appropriate service in a timely manner A process improvement project commenced late March 2019 to work through understanding the problems with flow through TWT, and identify solutions by determining the root causes of the problems. Root causes identified: • Process for triage and admission not optimal • Mon to Fri operation for some services, resources and roles • Care planning and integration bet CMHS and TWT not consistent • Discharge planning starting time inconsistent • Insufficient collaboration between community and TWT for unplanned discharges • *Barriers to discharge impact LOS* (this was identified as being out of scope for this project) The multidisciplinary team worked through a series of workshops to define a new care pathway that addressed these root causes. In addition, enhancement of the Chips whiteboard and enabling Zoom technology is being addressed to further address the issue of collaboration and integrated care planning between CMHS and TWT. While this process has been in progress, there have been positive changes in the LOS and earlier admissions. The project will be handed to the business to implement to all staff in Mental Health services.
1.2 Reason for project close	As agreed with the Mental Health Service Director, Performance Improvement project management resource will be reallocated at the end of August 2019. The project will be handed to the service to complete implementation.
1.3 Project highlights	• Collaboration and improved relationships between community and inpatient services • Recognition of the need for fundamental practices to be embedded to enable integrated care provision • Clinical leadership providing clear direction • Development of a service user centred pathway making the best use of clinical resources
1.4 Summary Recommendations	• Project Sponsor to accept handover to BAU for implementation • Implement new care pathway as standard practice for Mental health service provision • Incorporate project measures into KPIs for acute flow • Integration of occupancy into the Integrated Operations Centre Dashboard

2. Project performance

2.1 Objectives

Performance against project objectives

- Reduce TWT occupancy to national KPI 85%
- Reduce barriers to discharge to enable increased flow through TWT
- Develop/ refine enablers for integrated care delivery (shared care plans, admission goals, discharge planning) to facilitate flow
- Increase admissions earlier in the day
- Improve experience for service users and whanau
- Improve experience for TWT and Community teams

2.2 Outcomes & benefits

Performance against desired target outcomes

TWT occupancy is a KPI that is measured monthly. Since the project started, there has been an improvement in occupancy towards the target of 85%. Further improvements are expected once the new pathway is implemented.
Barriers to discharge are now out of scope for this project, so will not be directly impacted through the solutions implemented.
Integrated care has been the focus of the new care pathway and a number of new ways have been introduced to engage and communicate between inpatient and community services. The expected outcome is an improved, streamlined, well planned service user experience; and improved relationships and experience for the inpatient and community teams.
The reporting method will change once handed over to BAU as current performance measurements are reported in Minitab (tool used by Performance Improvement team)

Performance against planned benefits	*Baseline*	*Target*	*Actual*
Improved Occupancy at Friday midday	*96%*	*85%*	*92%*
% of Admissions before 2pm	*28%*	*TBC*	*20%*
Length of stay in TWT (Average)	*30days*	*21days*	*19 days*

2.3 Outputs / deliverables

Performance against project objectives

Continue measuring performance against planned benefits. The actual figures cover a period rather than a monthly average. On handover to BAU, the reporting of performance will be done weekly or monthly as per usual reporting frequency.

2.4 Recommendations

- SCDs to continue to provide leadership with internal project resource to roll out the new care pathway within the agreed timeframe
- Chips whiteboard changes to be completed and implemented across inpatient and community services
- Zoom technology rolled out to all clinicians
- Adoption of the new care pathway as policy for Mental health service provision
- Continued monitoring of key project measures for 1 year following handover to BAU
- Recruit to the Acute Care Coordinator role and use this role as a key enabler of the new care pathway
- Work with the Integrated Operations Centre (IOC) to incorporate Mental health service occupancy data onto the IOC Dashboard

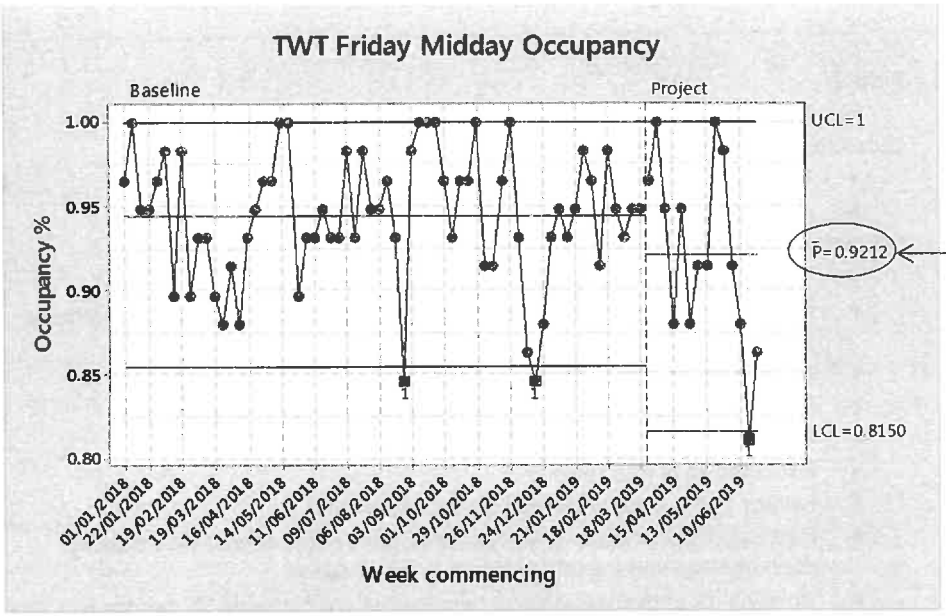
3. Lessons learned

3.1 Process & engagement	• Reflection from Improvement Project Manager • Project team reflections to follow
3.2 What worked well?	• Using a structured approach with opportunities to define expected behaviours • Providing a neutral perspective and asking questions to challenge the status quo, encourage alternate views to solve age old issues • Clinical leads providing guidance on membership of the project team, regular check ins on progress, and adjusting the approach when required • Having representatives from both the community and impatient teams Having visible leadership in the workshops
3.3 What could be improved?	• Timing between workshops initially was long (4-6 weeks in between) meaning momentum was lost and engagement with the DMAIC approach waned • Prior to inviting a large group of project team members, scoping the problem with the clinical leads to clearly define what the focus of each workshop will be.

4. Close activities

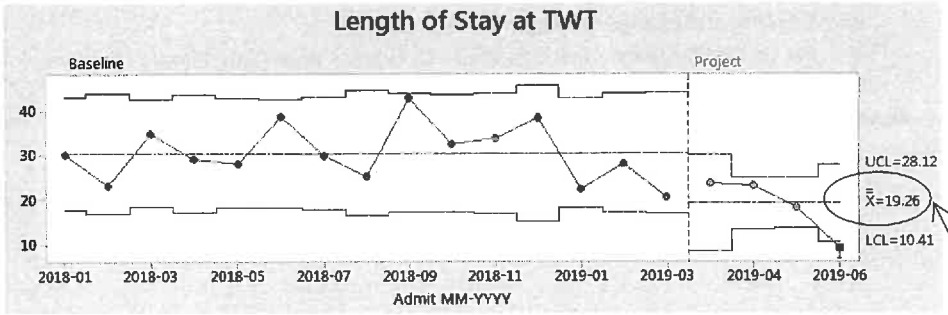
4.1 Project close activities	• Risks
	  • No project resource assigned to implement new pathway
	• Outcomes yet to be achieved
	  • Reduction in after-hours admissions
	  • Occupancy at 85%
	• Operational Activities
	  • Pilot of Prioritisation tool
	  • Pilot of new format MDM, Care Planning meeting, and Immediate discharge process
	  • Agreement on Care planning meeting structure
	  • Zoom technology enabled across all relevant sites/computers
	  • Chips whiteboard installed on all relevant computers
	  • Recruitment of ACC role
	  • Review and update of Occupancy escalation plan
	  • Pilot use of the Transition lounge for suitable patients who are ready for discharge and waiting for transport or medications
	  • Timeline for implementation of new Acute Care Pathway – 6 months to 1 year to fully embed
	  • Training and change management activities
	  • Set up regular team meetings Wed - Di Evans – Wed (Sati, Eileen, Christine, Anne, John, Allen)
	• Benefits realisation
	  • Handover project reporting to Patrick Firkin (BA – Mental Health services)

5. Project Measures



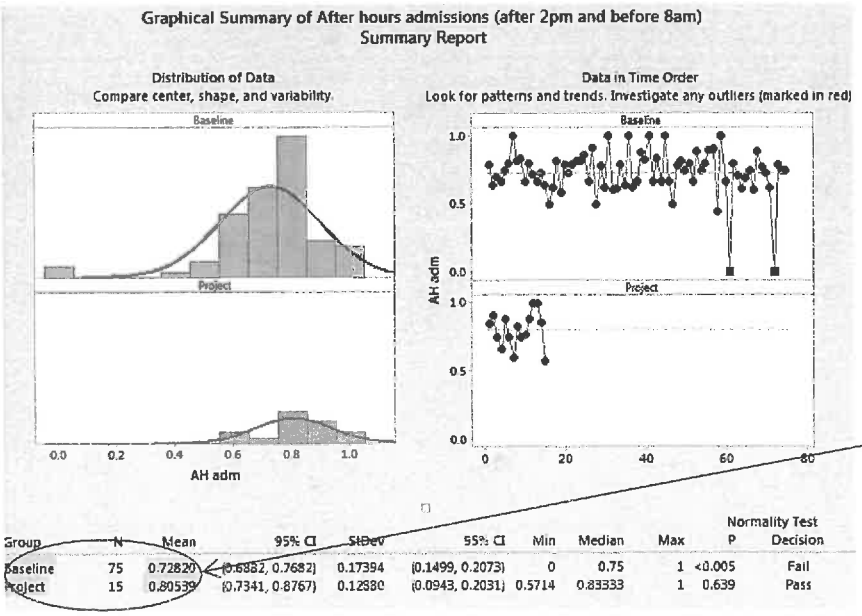
This graph plots every Friday midday occupancy point from 1 Jan 2018 to 30 Jun 2019.

There was a reduction in the average occupancy to 92% in the project phase and this value is trending down.



This graph took each LOS point for every patient who was discharged between Jan 2018 and Jun 2019 and averages the length of stay per month.

There was a reduction in the average monthly LOS to 19 days in the project phase and this value is trending down.



Group	N	Mean	95% CI	StDev	95% CI	Min	Median	Max	Normality Test P	Decision
Baseline	75	0.72820	(0.6882, 0.7682)	0.17394	(0.1499, 0.2073)	0	0.75	1	<0.005	Fail
Project	15	0.80539	(0.7341, 0.8767)	0.12980	(0.0943, 0.2031)	0.5714	0.83333	1	0.639	Pass

This graph plots the% of admissions after hours (after 2pm and before 8am) between Jan 2018 and Jun 2019

There has been an increase in the percentage of admissions after hours in the project phase compared to baseline.

This measure is a key success measure of the new care pathway so will be essential for tracking on-going.

Appendices

A. Close phase checklist
B. Pharmacy order sheet
C. DAS (current state)
D. New pathway
E. Prioritisation tool

Appendix A: Close phase checklist

This section includes a checklist of things that should be done during project closure, and includes any notes that may need to be carried through transition to operations. Mark these items as complete/not complete with an 'x' (or N/A if not relevant for the project) and add any relevant comments before the sponsor approves this closure report

Question	Answer	Comment
Have all project deliverables been signed-off by, and handed over to, the Change Owner(s) or Project Sponsor?	☒ Yes ☐ No ☐ N/A	
If there are recurring maintenance/operational costs to be accounted for, have these been planned for?	☐ Yes ☐ No ☒ N/A	
Have all outstanding tasks, risks and issues been assigned ownership, with adequate management strategies or mitigations planned?	☒ Yes ☐ No ☐ N/A	
Has project closure been communicated to stakeholders?	☒ Yes ☐ No ☐ N/A	
Were stakeholders provided with an opportunity to provide feedback about the deliverables and their satisfaction?	☒ Yes ☐ No ☐ N/A	
Have any lessons learned been captured and recorded for future improvement?	☒ Yes ☐ No ☐ N/A	
Has there been appreciation expressed to the project team?	☒ Yes ☐ No ☐ N/A	
Has this project delivered the outcomes expected (or are they still on track for realisation post project close)?	☒ Yes ☐ No ☐ N/A	
Is an on-going outcome/benefits measurement plan in place?	☒ Yes ☐ No ☐ N/A	
Have all project assets (phones, laptops, access cards etc.) been reallocated or returned?	☐ Yes ☐ No ☒ N/A	
Have all project resources have been reassigned or released as appropriate?	☒ Yes ☐ No ☐ N/A	
Have all project documents and artefacts been update and archived, and copies provided to the EPMO?	☐ Yes ☐ No ☐ N/A	
Has the EPMO or sub-portfolio endorsed this project to close?	☐ Yes ☐ No ☐ N/A	

Appendix B – Pharmacy Order sheet

AUCKLAND

SURNAME _____ NHI _____

FIRST NAMES _____

DATE OF BIRTH ___/___/___ SEX _____

Please attach patient label here

TE WHETU TAWERA MEDICATION ORDER SHEET

Te Kakenga (Ward B) Leave medication order sheet

To: Pharmacy Dispensary Fax 22301 Ph 22300 **Telephone of Ward 23003**

Date **Sent By**

Number of pages, including cover sheet :

For leave medication orders only. Discharge medication to be supplied from level 5 ACH retail pharmacy or a community pharmacy via outpatient script

To order medicines for use on ward, place the yellow ordering stickers next to the items required, and scan the chart to pharmacy.

What medicines do you need?

Please place yellow ordering stickers next to each medicine required

For PRN medication: please write the quantities required of each

Medication	Qty	Medication	Qty	Medication	Qty

Dates of leave

On Leave From Te Whetu Tawera	Date:
	Time:
Returning to Te Whetu Tawera	Date:
	Time:

How would you like the medicine packed?

Please circle below:

Medication boxes	Blister Pack

When do you need this by?

Required time: Urgent (immediately) ☐ Next delivery run (1100, 1400, 1800, EOD) ☐

Additional information:

PAGE 1

06/13

Te Whetu Tawera Pharmacy Scanning Form

Appendix D- Mental Health Acute Care Pathway

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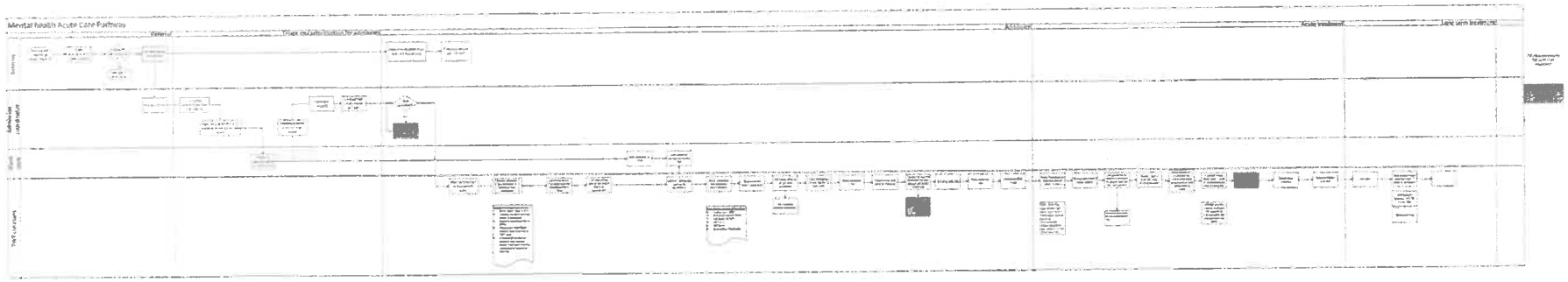

Appendix E - Draft Prioritisation tool

Based on assessing the 5 "Ps"

1. Predisposing elements
2. Presenting symptoms
3. Protective environment
4. Perpetuating factors
5. Precipitating factors

Prioritisation Criteria	Answer	Score
MH Act	Yes	1
All community options have been considered (respite/ PAC/ family)	Yes	1
Current location (Police = 3, ED = 2, Community (home/CMHC/respite = 1)	Police (or police on the way)	3
Not responding to assertive treatment OR refusing meds	Yes	1
Significant consequences of not being admitted?	Yes	1
Imminent risk or unpredictable risk	Yes	1
Previous or recent non-response to community management	Yes	1
Code called	Yes	1
Cumulating vulnerability likely to lead to risk	Yes	1
Level of risk (High = 3, Medium =2, Low = 1)	3	3
Total score for prioritisation	**Maximum score**	**14**

13th May 2019

Subject: Proposed changes to the Acute Admission Coordinator role.

Background

The ADHB nursing model at Te Whetu Tawera, currently incorporates an acute admissions coordinator role within the Adult acute inpatient setting. This role is responsible for the effective and efficient coordination and liaison of potential admissions to the unit from up to eight different referring teams and is a Monday – Friday 8am – 4.30pm role.

Given the on-going challenges associated with increased demand and there have been some challenges with the role in the way it is currently operating, which have contributed to an increasing level of tension between inpatient and community services.

At the present time, the role is focused on the movement of service users within the inpatient setting. The intention of this role is to manage the admission pathway, including where possible accessing beds out of the ADHB catchment and having a clear understanding of all available respite beds that can be utilised as an alternative to an admission into the acute mental health unit and to facilitate an effective discharge process.

Proposal

The current Acute Admission Coordinator position is vacant which provides a timely opportunity to look at the current functioning of this role, and gaps to effective service delivery. Having a cohesive acute admission coordinator as part of the acute pathway is a priority to improve the flow and linkages between inpatient and community service groups.

It is proposed that the current AAC role will be redesigned to have a greater focus in linking with the community. Therefore the position will be relocated to the community and expected to work across both the inpatient and community service groups (High and Complex Needs, Adult Community and Child and Youth).

The role will be responsible for:

- the coordination of admissions to Te Whetu Tawera
- Identifying acute alternatives for services users; either at the point of discharge (if a step down model of care is required) or as an alternative option to an acute inpatient admission
- Liaising with the community teams plus daily review of service users in respite services.

The role will be integral to flow across the continuum of care, with intentional linkages and care co-ordination with the four adult community mental health teams, Manawanui, Lotofale, Hapei Ora, ACOS, Liaison Psychiatry and to a lesser extent Aranui Ora and Tupu Ora.

The role will report to the Adult Service Clinical Director and will be responsible for ensuring effective flow across the continuum.

Any issues of concern in regards to patient will be escalated to the CTL or NUM of the respective areas and a plan will be developed in conjunction with the leadership team to address the issues.

A range of KPIs will be developed to monitor the effectiveness of the admission and discharge pathway. This will include the:

- Purpose of admission
- Review of all admissions which occur before 3pm Monday – Sunday
- Review of all admissions which occur out of hours
- Monitoring and completion of discharges by 12 midday
- Goals of admission are met and service users discharged as per plan
- There is a reduction in the barriers to discharge

Although the role will be based at the Greenlane Clinical Centre, it is expected that the role will be able to work from a range of sites and would be required to link in with all teams to understand the demand at various times throughout the day, to assist in planning the effective use of resources.

The role will also have a base at Te Whetu Tawera and would be expected to work across Greenlane and Te Whetu Tawera as well as utilising virtual technology such as zoom and real presence. The Greenlane shuttle (which operates every 15 minutes) can be used for transportation purposes.

The role will operate within normal business hours (8am-4.30pm Monday to Friday). Out of hours admissions and discharges will be organised by URS and / or psych Liaison as per the usual processes.

Advantages of this proposal

- Improves flow across inpatient and community service groups
- There is greater overall knowledge of the demand for beds on any day
- Single point of access for respite and acute beds in TWT and outside ADHB area
- Strengthens an integrated whole of system approach (inpatient and community) to resource management.
- There is a clear understanding of the roles and responsibility of a AAC role
- The role would sit as part of the senior nursing group with and be required to have a senior nurse's portfolio.
- There would be greater involvement in quality initiatives and improving the flow across the inpatient system of care.
- Clear knowledge of all parts of the system and ability to escalate potential issues earlier

Risks

- Potential to become part of the URS team or adult service group given the role reports to the SCD
- Increase level of travel impacting on time for day to day work due to stakeholder work required
- Backfill options need to be considered for annual leave and sick leave

With the AAC role being currently vacant it is recommended that the role is moved into a community service group role and changed to reflect the needs of acute mental health services across the continuum.